TEXAS BEHAVIORAL HEALTH EXECUTIVE COUNCIL
TEXAS STATE BOARD OF SOCIAL WORKER EXAMINERS
Non-Clinical Supervision Plan for Independent Practice Recognition (IPR)

I. Supervisee's Information

Supervisee Name (Last, First)	License Number

II. Supervisor's Information

Are you a board-approved supervisor? ☐ Yes ☐ No

Supervisor Name (Last, First)	License Number

This plan reflects only a change in supervisor: ☐ Yes ☐ No

III. Professional Experience to be supervised:

☐ Licensed Baccalaureate Social Worker (LBSW) for Independent Practice Recognition

☐ Licensed Master Social Worker (LMSW) for Independent Practice Recognition

IV. Supervision Schedule

Beginning Date of Supervision: _____

****(Supervision may begin up to 30 days before the plan is submitted for approval. If approval is not granted, no creditable experience can be granted.)****

Supervision Sessions per Month: _____

V. Supervision Process (to be completed by supervisor)

Describe the supervisee's work setting(s):

Describe the clients served:

Describe the supervisee's duties and responsibilities including treatment methods utilized:

Formulate four goals for the supervision:

1. _____
2. _____
3. _____
4. _____

Methods of supervision to be used:

_____

_____

VI. Attachments to Include with Supervision Plan

☐ If supervision of agency-based clients is done outside the agency setting, a letter from the agency supervisor or administrator approving the supervision must be attached.

VII. Comments

_____

_____

_____

_____

_____

VIII. Affidavit of Understanding and Signatures (initial by supervisee and supervisor)

_____ I hereby certify that I have received and reviewed a copy of regulations pertaining to supervision for specialty recognition in the state of Texas. I understand that I must observe and comply with the supervision guidelines set forth in the rules.

_____ Under penalties of perjury, I declare and affirm that the statements made in the supervision plan, including accompanying statements, are true, complete and correct. I understand that any false or misleading information in, or in connection with my supervision plan may be cause for denial or loss supervision time received and/or loss of licensure.

_____ _____

Supervisee Signature Date

_____

Printed Name of Supervisee

_____ _____

Supervisor Signature Date

_____

Printed Name of Supervisor

Submit to:

TX BHEC TSBSWE
333 Guadalupe, Ste. 3-900
Austin, TX 78701